Personal Support Plan

Name:	Effective Date of Plan:

Individual Goods and Service Criteria

Individual goods and services must be directed exclusively toward the benefit of the individual are the least costly alternative that reasonably meets the individual's assessed need and meets the following requirements.

*** Goods and services projected to exceed $2,000 (annual aggregate) require prior approval by the DDP Regional Manager.**

The service, equipment or supply is designed to meet the participant's functional and medical needs by advancing the outcomes in the plan of care.
Functional remedially necessary: appropriate to assist the person in increased independence and integration in their environment/community.
Medical medically necessary: appropriate and effective for the medical needs and health and safety of the person.

(If marked **No** to all questions then proceed)

Yes	No	Please mark yes or no to the following questions.
		These purchases are prohibited by the Federal or State statues or regulations
		Do these purchases include experimental goods and services
		The service equipment or supply is available through another source. (If **no,** denial from Medicaid or other sources is required)

(If one or more of the following additional criteria are met with a **Yes** answer then proceed)

Yes	No	Please mark yes or no to the following questions.
		The services, equipment or supply promotes inclusion in the community and increases the participants functioning related to the disability
		The service equipment or supply increases the person's safety in the home environment
		The service equipment or supply decreases the individual's dependence on other Medicaid Services.

Explain what each service, equipment or supply is and how it is related to the <u>person's</u> disability and how it would enhance opportunities for the person to achieve their desired outcome.

Provide **documentation** of the cost of the item/items, and provide a **prescription** or **letter** from the professional recommending these purchase/purchases. Also provide documentation of Medicaid denial. **(These items need to be attached to the PSP document and need to be present before purchase of the service requested.) All receipts and/or packing slips need to accompany the purchase.**

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Regional Manager Approval over $2,000:	☐**yes** ☐**no**	**Name of Regional Manager:**		**Date:**	

If Regional Manager is declining request explain why:

Section VIII. Outcomes

Vision Statement:

<u>Outcome</u>: *Written to answer this question,:* **"What do I want to do this year?"**

<u>Assessment tool/s used:</u>

Actions (Approach): How do I get there? How will this be accomplished? *Include name of provider agency and title of responsible person.*	**Start Date/ Completion Date**	**Status/Progress**